NORTHERN **HEALTH**
authority

Health Service Redesign and
Budget Management Plan

2003-04 to 2005-06

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1. Executive Summary

Vision and Mission

The Northern Health Authority (NHA) has a positive vision for the future. Our long-term goal is to promote improved health for all Northerners – keeping people healthy in the North, with access to specialized services when needed.

The vision of the Northern Health Authority is to be a model of excellence in rural health care. Our mission is to build and strengthen the health of communities, relationships and people in Northern British Columbia through community partnerships, health promotion, health services, learning and research. We will monitor progress by continually measuring service quality, access to services, our work life quality and costs.

Opportunities and Challenges

Our region covers the northern two thirds of the province. This vast geography, combined with the remoteness of the region, presents challenges in service accessibility, recruitment of health professionals and communication and consultation with our communities. Our opportunities lie in taking a focused, planned approach to the issues, working with communities to take action and monitoring our progress. We have a talented new board, strong management team and dedicated staff focused on working across service sectors to deliver services as close to where people live as possible and ensuring access to specialty services when they are needed. Our commitment to effective communication and relationship building will help us become a model of excellence in rural health care.

NHA Successes in 2002-03

This past year has been a time of development and building for the NHA. We have refined our organizational structure, built a strong management team and developed service plans that are the foundation upon which we can achieve our goals to meet the unique needs and circumstances of the people of the North.

Our focus on incremental change over the last year has resulted in accomplishments in all sectors of our organization.

Acute Care

- The NHA implemented service redesign plans that included adjustments in bed numbers, how specialist services are distributed, co-location of services and enlargement of emergency and ambulatory facilities at Prince George Regional Hospital. Laboratory, diagnostic imaging and pharmacy services focused on achieving benchmarks that resulted in savings to the organization and are developing regional processes and standards.

Home and Community Care

- A key focus was on managing Alternate Level of Care (ALC) clients through improved discharge planning. New wait list procedures have been implemented at all Long-term Care Facilities and complex care and independent living needs analyses and catchment area plans have been completed to 2005. Board approved catchment plans for

community enhancements in home support, home care nursing and rehabilitation are being implemented.

Public Health and Preventive Programs

- Multidisciplinary community health planning teams have been established for Child/Youth/Family, Chronic Disease and Injury Prevention, Communicable Disease, and Environmental Health. Coordination of services and reduction of overhead costs has been achieved through co-location of NHA programs and services by developing Community Health Centres.

Mental Health and Addictions

- Ten Riverview replacement units were completed with the opening of Iris House in Prince George. An early intervention plan was implemented and telehealth service and education for remote areas were developed. Continuity of care was improved through improvements in discharge planning and coordination among community, hospital and services partners such as Ministry of Child and Family Development (MCFD). An Alcohol & Drug Plan for a regional system of care was approved by the Board and is being implemented.

Aboriginal Health

- A consultation with over 80 aboriginal communities was undertaken, providing the basis upon which an Aboriginal Health Action Plan is being completed. A number of community initiatives were undertaken to reduce high-risk behaviours in vulnerable populations. A focus on effective management of hospital stays resulted in the development of a number of volunteer resources such as "Aunties in Action" and the "Bed and Bannock" Hostel in Prince George.

Primary Health Care

- NHA has received $4.2 million from the Health Canada Health Transition Fund to implement a 3-year plan focused on integration of services and clinical knowledge and skill development.

Corporate Services

- A key focus of 2002-03 has been the regional integration of organizational supports including human resources and payroll information systems, financial information systems, and a wide area network. Redesign of human resources, materials management, laundry, housekeeping and food services, plant/energy/property, finance and payroll has resulted in reductions in full time equivalents (FTEs), development of standardized practices and good progress toward achievement of benchmarks.

Looking forward, we must move beyond improvements in individual departments to improvements in the organization and delivery of our services in each community and the entire Northern Health Authority.

NHA Service Plans for 2003-04 to 2005-06

The NHA plan reflects key priorities that have been identified through the Board and Senior Executive in response to the service needs, challenges and issues in the delivery of health programs and services across the north. It aligns with the Ministry goals and objectives and requirements laid out in the Performance Agreement 2003-04.

Acute Care

The best possible patient care will always be our top priority. We will meet provincial standards that have been set for surgical and procedural services and access to emergency care. In addition, we will foster the development of community health centers in small communities, develop and implement a chronic disease management strategy and continue to participate in provincial health system redesign.

Home and Community Care

A key emphasis will continue to be on supporting people to stay in their homes as long as possible with access to services that meet their needs as close to home as possible. We will continue to improve discharge planning, enhance community services including palliative care, and support initiatives to improve aboriginal access to health services. Long-term care facilities will be developed to meet the needs of complex care clients and work will proceed to provide independent living units.

Community Programs and Aboriginal Health

Mental Health and Addiction Services will continue to shift to an early intervention approach, continue to improve continuity of care and proceed with implementation of the redesign plan for Alcohol and Drug programs approved by the NHA Board. Mental Health will continue to work with other sectors to decrease level of ALC days for mental health, alcohol and drug patients and improve continuity of care and follow-up after hospital discharge.

Public/population health will continue to collaborate with the Ministry of Health Planning in the development of core public health programs. Program plans will be developed for an NHA-wide system of integrated services focusing on communicable disease; child/youth/family; chronic disease and injury prevention; regional tobacco strategy, and environmental health. An ongoing priority is to reduce the incidence of communicable disease in the NHA and to develop an NHA-wide population health strategy.

The Aboriginal Health Services Plan will be implemented to improve access to primary and secondary prevention programs, build capacity in front line and management, and enhance working relationships between the NHA, First Nations and Inuit Health Branch and other government departments. Community specific action plans will be developed in areas of common interest and opportunity to improve health or health services.

Primary Health Care

The 3-year primary health care plan will be implemented. This plan will increase access to primary health care through integration of services in community health centers, and a specialized health center in Prince George to service socially/economically disadvantaged; and improve the quality of primary health care through initiatives that support the integration of community health services such as education and training of health care workers and public education.

Clinical Workforce

The NHA will forecast future requirements for clinical staff and implement strategies to recruit, retain, educate and develop its clinical work force.

Organizational Supports

Key priorities for 2003-04 to 2005-06 will be to achieve benchmarks in administration and support, strengthen planning processes and continue to integrate and implement NHA-wide supports such as the Clinical Information System and telehealth. We will complete the implementation of redesign plans for laboratory, diagnostic imaging, materials management, food services, housekeeping and laundry and develop an integrated capital plan for all regional facilities and capital equipment.

We will focus on improving internal and external communications through the development and implementation of a Communication Strategy and develop an approach to ensuring quality services in the NHA.

Financial Management

Our ongoing priority is to ensure efficient and effective use of limited resources – managing and delivering services such that operating results are equivalent or better than those projected in the budget management plans.

Conclusion

The NHA Health Service Redesign and Budget Management Plan has been prepared to meet the unique needs and circumstances of the people of the North and to meet the New Era commitments of the Government of British Columbia. With a strong focus on access to services, and integration and coordination of operations, we can more effectively serve the population of our region. Our ongoing commitment to "upstream solutions" will help us achieve our long-term goal to promote improved health for all Northerners. Living by our mission – to build and strengthen the health of communities, relationships and people in Northern British Columbia through community partnerships, health promotion, health services, learning and research, we will continue to move toward our vision to be a "model of excellence in rural health care".

2. Strategic Context

2.1 Introduction

The Northern Health Authority has a positive vision for the future. Our vision is tied to the belief that we need "upstream solutions". Upstream describes not only the historic purpose and location of our communities but also their strength as the source of their residents' wealth and health. "Upstream solutions" refers to keeping people healthy closer to home and ensuring an easy passage to specialized services when needed.

Our long-term goal is to promote improved health for all Northerners and reduce the demand for hospital care. Our goals are founded on a strong commitment to meeting the needs of the people of the North.

2.2 Vision

We have recently engaged our staff and our Board in a consultative process to develop a vision, mission and value statements to guide us to our desired future.

"The vision of the Northern Health Authority is to be a model of excellence in rural health care."

2.3 Mission

This vision will guide us to upstream solutions as we carry out our mission:

- The Northern Health Authority will build and strengthen the health of communities, relationships, and people in Northern British Columbia;
- We will do this through community partnerships, health promotion, health services, learning and research;
- We will monitor progress by continually measuring service quality, access to service, our work life quality, and costs.

2.4 Value Statement

Our fundamental value is clear and direct –

"To live by our mission."

2.5 Challenges and Opportunities

The Northern Health Authority covers the northern two thirds of the province of British Columbia. This is a vast geographic area with a widely dispersed population – we only have 7% of the provincial population. This geography and population distribution creates challenges that are not faced by the rest of the province, not the least of which is access to services. Not all services can be in all communities – decisions about the nature, level and location of services are difficult.

The remoteness and rural nature of the NHA, and perceived lack of community amenities and professional resources, has also been a disadvantage in our recruitment efforts. The shortage of physicians, nurses and other health professionals is an issue that is common across Canada. Here in the NHA, this already grave issue is aggravated by our remote geography.

The north has the highest projected growth rate of seniors in British Columbia, with a 48% projected increase by 2010. 13% of the population is aboriginal, the highest proportion in the province, and 35% of all First Nations people in BC live in the NHA. In general, the health status of our population is lower than that for the rest of the province – our people are unhealthier.

Communication and consultation with our communities has been a significant challenge that we have not yet adequately addressed. In our numerous and dispersed rural communities, regular face-to-face and familiar communications is a challenge. The state of technology and telecommunications varies widely in our communities. This variability of technology impacts not only our communications but also the delivery of services reliant on technology, such as telehealth.

The Northern Health Authority has opportunities to address the challenges by taking a focused and planned approach to the issues, working together to take action and monitor our progress. The NHA has a talented new Board and leadership team. We are strengthening our management structure - using the organizational structure more effectively and focusing on accountability for business plan targets.

We have experienced, dedicated staff committed to delivering high quality programs and services. We have a strong focus on working across service sectors to deliver services as close to where people live as possible and ensuring access to specialty services when they are needed.

Our work with UBC and UNBC to establish a Northern Medical Program will result in physicians trained for practice in rural and northern areas. The northern program is designed to attract rural, northern, and aboriginal students. The program will accept 22 new medical students annually and will enroll its first students in 2004.

Our challenges lend themselves to innovative primary health care models to meet the everyday health care needs of our citizens. Our primary care plan focuses on laying the groundwork for implementing primary care initiatives in 6 to 8 communities by 2005-06.

Finally, we have a strong commitment to communicate effectively with our communities to build strong relationships and partnerships that will help us become a model of excellence in rural health care.

3. NHA Successes in 2002-03

Our focus on incremental change over the last year has resulted in accomplishments in all sectors of our organization. We are proud to report our achievements on key initiatives as follows.

3.1 Acute Care

Clinical Networks

- The NHA has been involved in Provincial Health Services Authority (PHSA) led provincial clinical reviews in emergency medicine and surgical services.
- Clinical networks will be more fully developed when a medical administration and Vice President Medicine are in place.
- An NHA-wide committee has made progress to enhance education and support for NHA nurses that provide obstetrical services.

Specialty Programs

- Specialist services in the Northwest and Northeast Health Service Delivery Areas (HSDA) are being coordinated and supported in Kitimat, Terrace, Prince Rupert, Fort St. John and Dawson Creek. A medical manpower plan has been developed by the Regional Medical Advisory Committee to determine needs across the NHA for specialist services.

Services Redesign

- Redesign plans in Quesnel, Burns Lake, Mackenzie, Prince Rupert, Terrace, Kitimat, Queen Charlotte Islands/Haida Gwaii, Chetwynd and Fort Nelson have included adjustments in bed numbers, co-location of services, development of community services and discharge planning.
- Multidisciplinary clinical program management teams have been established in the Northeast HSDA for inpatient, emergency/ambulatory care, surgical, and maternal child services.

Prince George Regional Hospital (PGRH) Redevelopment

- Emergency and ambulatory facilities are being enlarged to support transition from inpatient to ambulatory care.
- Refer to Table 1 on page 9 for a summary of 2002-03 bed changes.

Laboratory, Diagnostic Imaging and Pharmacy

- Laboratory Services implemented best practices in site-specific services through centralization of testing of microbiology, adopting Adverse Event reporting protocols for blood transfusions and blood products, and adopting Health Canada and Canadian Blood Services recommendations.
- Benchmarking of all laboratories has resulted in a net reduction of 30 Full Time Equivalents.
- Diagnostic Imaging has also benchmarked to this standard resulting in a net reduction of 3 FTEs and redistribution of staffing to better cope with workload.
- Procedure waitlists are being monitored for specialty imaging services such as MRI, CT, and specialty Ultrasound.
- Imaging and Laboratory departments have worked in partnership with the Northern Alberta Institute of Technology (NAIT) to train 9 laboratory technologists in basic medical imaging so that staff can be utilized in both departments.
- An NHA-wide wide drug formulary was developed and is being implemented on a facility-by-facility basis.
- Unit dose packaging has expanded through cooperative efforts and some centralization has occurred. Intravenous admixture services have expanded through a number of areas in the NHA with work continuing on this initiative.
- Pharmacy staff, in conjunction with the BC Drug and Poison Information Centre, has developed a plan for NHA-wide access to antidotes that allows for complete coverage while minimizing costs.
- A move towards centralization of pharmaceutical inventory procurement has reduced costs through standardized practices.
- Locum relief pharmacists have been provided by PGRH and contract pharmacist staff; a significant step in retaining pharmacists in the north.

Quality Management

- Discussions to build on existing risk management and quality improvement processes have been initiated in facilities in order to develop an NHA-wide approach to these issues. Preliminary discussions related to the upcoming accreditation process have also begun.

Education

- The NHA has accessed $400,000 in funding for nursing specialty education from the provincial nursing strategy funds. HSDA education committees have been established to develop education plans and an NHA-wide committee has been established to develop a consistent approach to LPN/RN staff mix.

Table 1 2002-03 Bed Changes Summary

Name	Location	Facility Role	Projected Total Beds 02-03	Actual Operational Beds 02-03	Comme
Chetwynd General Hospital	Chetwynd	Small Community Hospital	5	5	Target met
Dawson Creek & District Hospital	Dawson Creek	Community Hospital	47	45	Target exceeded
Fort Nelson Hospital	Fort Nelson	Community Hospital [3]	25 (note: original target of 10 amended)	25	Plan under review
Fort St. John Hospital & Health Centre	Fort St. John	Community Hospital [3]	51	44	Target exceeded
Lakes District Hospital and Health Centre	Burns Lake	Community Hospital	14	13	Target exceeded
Stuart Lake Hospital	Fort St. James	Small Community Hospital	6	6	Target met
Mackenzie & District Hospital	Mackenzie	Small Community Hospital	5	5	Target met
McBride & District Hospital	McBride	Small Community Hospital	3	3	Target met
Prince George Regional Hospital	Prince George	Regional Hospital	206	203	Target exceeded
G.R. Baker Memorial Hospital	Quesnel	Community Hospital [2]	35	31	Target exceeded
St. John Hospital	Vanderhoof	Community Hospital [2]	26	24	Target exceeded
Wrinch Memorial Hospital	Hazelton	Small Community Hospital	9	15	Plan under review
Kitimat General Hospital	Kitimat	Community Hospital [1]	10	18	Will remain at 18 beds pending further review. (See also Terrace)
Masset Hospital	Masset	Small Community Hospital	4	4	Target met
Prince Rupert Regional Hospital	Prince Rupert	Community Hospital [1]	33	31	Target exceeded
Queen Charlotte Islands Hospital	Queen Charlotte City	Small Community Hospital	5	8	Plan under review
Bulkley Valley District Hospital	Smithers	Community Hospital	35	25	Target exceeded
Stewart General Hospital	Stewart	Small Community Hospital	3	3	Target met
Mills Memorial Hospital	Terrace	Community Hospital [1]	56	39	Terrace will continue to operate at 39 beds for the foreseeable future. (See also Kitimat)

1 Community Hospitals in Prince Rupert, Kitimat and Terrace work to coordinate services
2 Community Hospitals in Vanderhoof and Quesnel continue to work towards offering services in collaboration with PGRH
3 Community Hospitals in Fort St. John and Dawson Creek work to coordinate services

3.2 Home and Community Care – Community and Residential

Alternate Level of Care (ALC)

- Home and Community Care are working with acute care and mental health to reduce length of stay and improve discharge planning through implementation of ALC strategies.
- Wait listing for long-term care facilities has been modified to accommodate ALC clients, with empty facility beds being used for ALC clients.
- The Northern Interior HSDA ALC Committee, with representation from home and community care, acute care and mental health, has reviewed ALC issues and identified options to manage the numbers of ALC patients. Northern Interior communities are beginning to implement some of the committee's recommendations. Similar teams are being structured in the Northeast and Northwest HSDAs.

Residential

- Complex care and independent living needs analyses and catchment area plans have been completed to 2005. Identified bed adjustments are being implemented. Request For Proposals and Expressions of Interest for Independent Living have been issued to commence the process for increasing the number of Independent Living Units.
- The Home and Community Care Management structure is in place.
- Implementation of the new assessment tool for residential care (MDS V2.0) is on target with Phase 1 being implemented in May 2003, Phase 2 scheduled for April 2004 and Phase 3 scheduled for 2005.
- New wait list procedures using needs-based criteria have been fully implemented at all Long Term Care Facilities.

Community

- With approval of Catchment Plans by the Board, community enhancements in home support, home care nursing and rehabilitation are being implemented. There was a reduction in the overall number of community clients served, as a result of seniors moving away from the NHA with their families due to economic conditions. With planned enhancements to community services in 2003-04, significant achievements toward targeted increases in the proportion of high care needs clients living in their own home are expected.
- The implementation of the assessment tool for home care (MDS-HC) is on track. A three-phase process will see implementation of Phase 1 in May 2003 with the final phase targeted for 2005.
- Home and community care services have been improved through implementation of best practice innovations, some of which include:
  - cultural sensitivity education available to all staff;
  - planning for the new Geriatric Assessment and Treatment Unit in Prince George, April 2004;
  - falls prevention initiatives;

- development of community partnerships to enhance services that allow people to stay in their homes longer, such as Handyman, and Meals on Wheels;
- adult day care centers in Dawson Creek and Vanderhoof; and
- creation of a Geriatric Network of Excellence.

3.3 Public Health and Preventive Programs

Integration of Programs and Comprehensive Planning

- The NHA collaborated with the Ministries of Health on the development of a core programs discussion paper and participated on a provincial advisory committee to finalize a core program document. This work is ongoing.
- Multidisciplinary community health planning teams for Child Youth Family; Chronic Disease and Injury Prevention; Communicable Disease; and Environmental Health have been established.
- The teams have developed draft plans and are beginning to inventory services and identify program priorities.

Co-location of Programs into Community Health Centres

- In a number of communities, there is an opportunity to both improve coordination of services and reduce overhead costs through co-location of NHA programs and services by developing Community Health Centres.
- Masset is moving ahead with the Community Health Centre approach, and Hazelton is in the planning stages. Burns Lake Public Health and Home and Community Care has co-located in the hospital, and Mackenzie has completed the co-location into a Community Health Centre. Chetwynd is now in the 'working drawing' phase to renovate the facility. Planning is also progressing in Fort Nelson.
- Construction of the South Side Facility (on the south side of Francois Lake) began in 2002 with substantial completion slated for 2003. This project is a partnership between the NHA, 3 First Nations Bands, and Health Canada; it will provide enhanced access to primary care for the residents of the area.
- Program Highlights:
  - expanded smoking cessation program NHA-wide.
  - launched 'Local Heroes' comprehensive mass media campaign.
  - launched inventory of sustainable best practices in the NHA.
  - Collaborated with School Districts 57 & 91 and UBC in an assessment of Readiness to Learn for all Kindergarten children.

3.4 Mental Health and Addictions

Continuity of Care, Availability and Access

- A mental health Early Intervention Plan was implemented. Telehealth service and education for remote areas was developed and SYNAPSE information system is ready for implementation, contingent on the wide area network. Targets for increased early intervention capacity are on track.
- ALC days have been managed through the introduction of a utilization management plan, development of capacity for

community placements, implementation of rapid response teams and increased psycho-geriatric assessments and placements.

- Continuity of care was improved through better use of admission and discharge planning protocol and of the information system. Coordination among community, hospital and services partners such as Ministry of Children and Family Development was improved. Utilization plans and reduction of ALOS is on track.
- 10 Riverview replacement units were completed with the expansion of beds at Iris House in Prince George. With the previous development of 5 tertiary beds in Dawson Creek, the NHA has completed a total of 25 units.
- Administrative services between programs have been coordinated within mental health services.

Addictions Services

- The NHA Board approved the Alcohol & Drug Plan in January 2003. The Plan for the development of an NHA-wide system of care is on track, and is consistent with NHA and Provincial expectations.
- Addictions successes include:
  - identification of the need to improve access and treatment for people with addictions;
  - consistent reporting across the NHA;
  - service planning to improve community capacity ; and
  - improved linkages for people with co-occurring disorders.

3.5 Aboriginal Health

Effective Management of Hospital Stays

- Staff resources in each HSDA are being developed in collaboration with the VP Clinical Services.
- An evaluation of the Aboriginal Patient Liaison Worker program was completed in February 2003.
- Volunteer resources including "Aunties in Action".

Aboriginal Health Planning

- A consultation strategy to hear from over 80 aboriginal communities, bands, tribal councils, and organizations within the Northern Health Authority was completed to identify areas of opportunity for strategies to improve aboriginal equity and access to services. Based upon this work, an Aboriginal Health Action Plan, approved by the NHA Board in May 2003, is being implemented.

Community Initiatives

- A number of initiatives were undertaken to reduce high-risk behaviours in vulnerable populations.
- The Aboriginal Health Initiative Program provided $1.1 million to First Nations, Metis and Inuit across the NHA for addictions, mental health, and chronic disease programs.
- Aboriginal Community Programs provides $1.3 million for the following programs:
  - Three Aboriginal mental health workers provide mental health outreach, one each in Prince Rupert, Smithers, and Prince George.

- The Sexual Abuse Intervention Program at the Prince George Native Friendship Centre, and the North West Band Social Workers Association provide sexual abuse prevention and follow up to children and youth.
- The Prince Rupert Friendship House and the Wetsuweten offered parenting programs.
- Fort Nelson Friendship Centre and Smithers Friendship Centre both deliver an HIV/AIDS program, albeit on limited budgets. Prince George has a needle exchange program.

3.6 Primary Health Care

- The NHA has received $4.2 M from the Health Canada Health Transition Fund to implement a 3-year plan. An NHA-wide plan has been completed with a focus on the integration of services and clinical knowledge and skill development. Initially, 4 communities have been identified to participate in Phase 1.

3.7 Corporate Services

Information Technology Services

- Information technology projects were implemented to support NHA-wide integration of organizational supports including human resources and payroll information systems, financial information systems, wide area network project, e-mail integration project and others.
- Training, hardware support and licensing have been standardized, and an integrated Helpdesk service has been implemented.
- Travel, telecommunication, and vendor licensing costs have been reduced through videoconferences, consolidation and renegotiations with telecom vendors and integration of information systems across the NHA. Estimated savings were $110,000 in 2002-03 with more expected in 2003-04.
- Implementation has begun on the IM/IT strategic plan and will help integrate clinical service, improve access to patient information and improve information quality.

Human Resources/Occupational Health and Safety

- The redesign of human resources has resulted in a number of accomplishments including:
  - Implementation of a web-based HR information system has combined 16 payroll and employee information databases.
  - All non-contract positions have been reviewed, evaluated and required salary adjustments made. A consistent set of benefits was adopted in April 2003.
  - HSDA Education Committees were established for 2003 to develop and implement an effective education strategy.
  - An Integrated Workplace Health and Safety strategy has been adopted in an effort to reduce overtime and sick leave. Staff hiring and partnerships with Workers Compensation Board and Occupational Health and Safety Agency for Healthcare are underway. As part of the integrated Workplace Health and Safety Initiative, the NHA has developed and integrated a full Employee and Family Assistance Program for all areas within the NHA. The NHA has also developed a Respect in the Workplace policy for implementation is 2003.

- A review and outline of physician recruitment support was completed. Support is now provided by one FTE and clerical support. Further review will be undertaken with the appointment of a VP of Medicine.

Materials Management

- The Northern Interior HSDA realized $440,000 in savings through participation in the Medbuy GPO contracts in 2002-03. The focus is now on working with Medbuy for existing contracts in the Northwest and Northeast HSDAs with anticipated savings of $700,000 in 2003-04.
- Centralization and consolidation of functions including capital acquisition, stores and distribution have resulted in a savings of 11.4 FTEs and $639,000.

Laundry, Housekeeping and Food Services

- Benchmarks have been achieved in 75% of NHA sites for Housekeeping and Food Services with minimal impact to service delivery. Redesign implementation is 70% complete for the three service areas, with an overall worked FTE reduction of 75 FTEs.

Redesign of Plant/Energy/Property

- Work continues on establishing standardized practices in the NHA. Costs have been reduced on a line-by-line basis. Energy utilization audits have been undertaken as a first step forward in an energy conservation initiative.
- A number of co-location initiatives are being pursued that will reduce lease expenditures and/or provide better health care by grouping services together.

Finance and Payroll

- Consolidation of finance and payroll and standardized policies and practices was a priority in 2002-03. Accomplishments include:
  - implementation of NHA-wide budget guidelines and standardized process;
  - NHA-wide financial and statistical chart of accounts and consolidated transactions and financial reporting;
  - consolidation of accounts payable;
  - implementation of new Human Resources Information System and consolidation of payroll services; and
  - consolidation of physician payments and implementation of new physician agreement.

During 2002-2003, The Northern Heath Authority made significant process in increasing the productivity of operational support services. The three-year target to reduce administrative and support services by 7% was achieved in the first year.

Significant progress was made in developing NHA-wide human resource, finance and information technology services. This progress is key to success in combining the sixteen organizations that preceded the NHA, into a single entity.

Looking forward, we must move beyond improvements in individual departments to improvements in organization and delivery of our services in each community and in the NHA.

4. NHA Services Plan for 2003-04 to 2005-06

4.1 Introduction

This plan correlates NHA strategies with the revised Ministry Service Plan 2003/04 – 2005/06. Ministry goals and objectives along with their related priority strategies are set out below.

Ministry Goals and Objectives	Priority Strategies
1. High Quality Patient Care	
Objective 1 Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/institutional care to more home/community care.	1: Hospital admissions prevention through increased community care 2: Post-acute alternatives 3: Effective management of acute care services in hospitals 4: Alternatives to institutional care 5: Build the foundation for integrated care networks
Objective 2 Provide tailored care for key segments of the population to better address their specific health care needs and improve their quality of life.	6: Better care for people with extensive care needs 7: Better care for people with chronic conditions 8: Better care for the dying 9: Improve the health status of aboriginal peoples
2. Improved Health and Wellness for British Columbians	
Objective 3 Keep people as healthy as possible by preventing disease, illness and disability and slowing the progression of chronic illness to minimize suffering and reduce care costs in the future.	10: Enhancing self-care and self-management 11: Protection from disease or injury
3. A Sustainable, Affordable Public Health System	
Objective 4 Manage within the available budget while meeting the priority needs of the population	12: Service quality enhancement for rural and smaller communities 13: Managing within budget allocation

4.2 Strategic Priorities

The NHA Board, management and staff have engaged in discussions and planning processes since the inception of the NHA to identify service needs, challenges and issues in the delivery of health programs and services across the north. While we recognize and accept that there is much to be done, we believe that we must focus our energy and resources to make gains in key priority areas.

This plan reflects priorities that have been identified through the Board and Senior Executive and are aligned with Ministry Goals and Objectives and Performance Agreement expectations. The key initiatives presented in the service plan section to follow are organized in the following priority areas.

Acute Care

We will meet provincial standards that have been set for surgical and procedural services and access to emergency care. The best possible patient care will always be our top priority. Acute care staffing will be assessed against patient needs, and acute care bed utilization will be adjusted to benchmarks with flexibility for peak periods.

Home and Community Care

A key emphasis will continue to be on supporting people to stay in their homes as long as possible with access to services that meet their needs as close to home as possible. Home and Community Care Service plans developed in 2002-03 will be implemented. We will also develop and implement a transition plan for the upgrading and replacement of long-term care facilities.

Community Programs

Our focus will be on development of core programs and integrated approaches to meeting identified population health issues with a priority on aboriginal health, mental health and addictions, and primary health care. Service plans developed in 2002-03 will be implemented in Public Health, Mental Health and Addictions. We intend to emphasize prevention and chronic disease management as we work towards improving the lives of the 300,000 people we serve.

Aboriginal Health

We will implement an Aboriginal Health Services Plan that will focus on building relationships; strengthening capacity to support improved planning and coordination of services; and improving access to services for aboriginal people.

Clinical Work Force

Recruiting, retaining, educating and developing our workforce continue to be a high priority. Our clinical human resources issues, particularly in medicine, nursing and pharmacy will be addressed in a multi-year strategy. The start-up of the Northern Medical Program in Prince George over the next couple of years will greatly boost medical education in the area.

Organizational Support

Redesign plans for operational support and administrative services will be completed. Ongoing advancements in technology will put us on the leading edge of northern and

rural health care excellence. Our strategic information systems plan will guide our development in this area. The building blocks for this plan will be in place with the completion of the wide area network in the summer of 2003.

Financial Management

The NHA has implemented a single financial system as well as a single human resources/payroll system. This, coupled with a sound budgeting and financial control system, will ensure sound fiscal management of the NHA.

The development of a multi-year Capital Asset Management Plan is a high priority. The NHA is participating in the pilot project for the Ministry funded assessment of acute and diagnostic and transfer centers. The final report from this study will facilitate the development of the NHA capital planning process.

4.3 Assumptions and Risks

The Health Service and Budget Management Plan is based on significant assumptions and risks known to management at the time of plan preparations. Specific financial assumptions, cost influences and labour rates are presented within the budget management section of this plan.

1. This plan assumes that the provincial economy will perform with modest growth in 2003-04 and 2004-05 such that previously stated provincial fund plans for the health sector will proceed.

2. The declining population of the Northern Health Authority will affect the health authority negatively in future years. The Ministry of Health continues to use the 1996 population of 320,000 for the NHA in its funding model. The NHA population according to the 2001 census is 298,715, a decline of 21,285. The plan assumes that the Ministry will not make these reductions in 2003-04 or 2004-05. (Note: There are some communities within the NHA increasing in population even though the NHA as a whole has declined.)

3. The application of the Population Needs Based Funding Model (PNBF) significantly disadvantages the Northern Health Authority.
   - The Standardized Mortality Ratio (SMR) for the NHA relative to British Columbia is 1.16. This means that after allowing for age differences between Health Authorities, there are 16% more deaths amongst Northerners annually than there would be if our health was as good as the average in British Columbia. The next highest SMR is for the Vancouver Island Health Authority at 1.01, showing that except for Northern, all other Health Authorities have similar health status. The SMR is not factored in the model.
   - The Ministry of Health funding model uses the number of aboriginal people, the number of low-income people, and the number of people receiving disability benefits as indirect indicators of health status. The effect of this approach gives the NHA only a 3% increase in funds for acute care and certain other services.
   - The declining population base represents a serious risk to future service levels.

4. Maintenance of a number of NHA services is contingent upon our ability to recruit and retain health professionals. This plan assumes that recruitment and retention programs will have sufficient success to enable modest growth in numbers of physicians, pharmacists and nurses. There are several key areas of vulnerability. These are:
   - pharmacists throughout the NHA;
   - pediatricians in Prince George and as a result the visibility of the Special Care Nursery and high risk obstetrical services; and
   - special unit nurses throughout the NHA but with the most serious deficits being operating room and intensive care nurses in Prince George.

Assumptions and Risks Continued

5. Provincial restructuring of the Ministry of Children and Family Development (MCFD) is proceeding and will most likely result in the creation of two regional structures for children's services (Aboriginal and Non-Aboriginal) with boundaries co-terminus with the Northern Health Authority.

   The MCFD budget will decline significantly during the process resulting in very significant service redesign. The NHA has many service linkages with MCFD clients, especially in public health, mental health, addictions, and pediatric services. It is likely that the NHA will face significant new demands in 2004-05 as a result of the change.

6. The Northern Medical Program (NMP) is a joint venture by UBC and UNBC with the first intake of students planned for September 2004. The NMP will be more dependent on non-academic practicing physicians for faculty than any other program in Canada. In parts of the latter two years of the program, students will travel to various communities for periods of training, however, much of their training will occur in Prince George.

Prince George Regional Hospital is not well supplied with Medical Specialists, therefore not well positioned to take on additional medical time commitments associated with teaching. Significant recruitment over the next two years could address this deficiency. However, 80% to 90% of the professional income of additional specialists would be generated by expanded provision of insured medical services. This expansion of activity would add $6-$8 million of costs to the operation of PGRH and would increase stresses related to recruitment. While some of the additional operating costs would result in decreased referrals out of the NHA, it is expected that three years would elapse before the funding model would recognize these changes. The NHA will face a significant operating cost pressure resulting from specialists' recruitment.

The Northern Medical Program is both an opportunity and a risk for the NHA. It is essential the NHA seek a consensus internally, with University and Medical Staff partners and with the Ministries of Advanced Education and Health Services on the scale and costs of hospital services to be offered in conjunction with this program. Failure to achieve such a consensus will result in significant conflict among these groups with negative consequences for all parties. This task will require significant effort by NHA leadership in the first and second quarter of 2003-04.

Assumptions and Risks Continued

7. The Ministry of Health is significantly reducing its capital funding as the Province attempts to move to other capital financing arrangements such as public-private partnerships. The capital facilities and equipment in the North require significant investment. The ability for the North to attract private investment is unknown at this time.

8. The NHA has developed a Strategic Information Systems plan that will support the redesign and delivery of the health services in the North. There will be a significant cost to this plan and the necessary resources have yet to be identified. Partnerships with other users and funding sources such as Canada Health Infoway Inc., Health Canada, Industry Canada, BC Ministry of Health, and others will be pursued to support this vital initiative.

4.4 Service Plan – Key Initiatives

The tables on the pages to follow identify NHA priorities for 2003-04 to 2005-06 and associated strategies to achieve success in the priority areas. Lead responsibility has been identified for each strategy, making this a working document from which NHA management and staff will take their direction. Indicators and targets, where developed and as directed in the performance agreement, provide sign posts of our progress. Implications of strategies, as applicable, describe linkages with other initiatives and impacts on the finances and operations of the NHA. Appendix A provides a cross referencing of NHA priorities and indicators/targets with the Ministry goals and objectives and the Performance Agreement 2003-04. Appendix B provides a summary of the indicators and targets along with historical data, where available.

4.4.1 Acute Care

Acute Care

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
1. Address issues of access to acute care (Refer to Table 2 on pages 24-25 for proposed 2003-04 to 2005-06 facility changes)	1.1 Improve discharge planning through integrated discharge planning processes in collaboration with primary care, home and community care, public health, mental health and addictions.	VP Clinical Services Chief Operating Officers (COOs) Health Service Administrators (HSAs)	- PAT 03/04: 5% Decrease in ALC days as % of total inpatient days (#6) - Decrease in patient days/1000 (#3) - Discharge Planning plan in place Jul/03 - Discharge Planning plan implemented Mar/04
	1.2 Manage length of stay/inpatient utilization through implementation of utilization management plans at all sites and application of MCAP (PGRH in 2003) system.	COOs HSAs	- ALOS at or better than ELOS (#8) - Utilization Management plans in place Jul/03 - Utilization Management plans implemented Mar/04 - MCAP in place at PGRH
	1.3 Prevent hospital admissions and match patients to community services.	COOs HSAs	- **PAT 03/04:** 5% Reduction in MNRH admissions (cases/1000) (#9)
	1.4 Collaborate with physicians to address access to specialist care including: - clinician-led program reviews to address access and sustainability; - networks for referral and quality assurance; and - telehealth for training and primary care support.	VP Medicine VP Clinical Services Chief Information Officer	- Process initiated Aug/03 or when VP Medicine is in place - **PAT 03/04:** Implementation of surgical services & emergency services reviews in collaboration with PHSA by Mar/04 (#12 & #13)

Acute Care

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
2. Foster the development of community health centre models of service delivery in small communities	2.1 Identify NHA-wide priorities and action plans for service co-locations based on service integration and cost reduction.	VP Clinical Services and COOs through primary health care plan	- Priorities & plans identified Jun/03
	2.2 Co-locate primary care, community services and acute care services. Develop integrated program planning and service delivery systems to meet community specific needs.	COOs HSAs	- Co-location complete Mar/04 - 2 sites per HSDA implemented by Mar/04
3. Develop and implement a Chronic Disease Management (CDM) Strategy	3.1 Develop and shift practice to a CDM approach with an initial focus on diabetes and heart disease: - Implement a Congestive Heart Failure pilot initiative in Terrace/Kitimat. - Partner with Healthy Heart Society to implement CDM approach in communities across the NHA.	VP Clinical Services VP Medicine	- Congestive Heart Failure pilot implemented in Terrace/Kitimat in 03/04 - Healthy Heart Society partnership implemented in 8 communities
4. Participate in provincial health system redesign	4.1 Collaborate with the PHSA; other health authorities and ministries in development of guidelines to better manage demands on the emergency health services.	VP Clinical Services VP Medicine	- **PAT 03/04:** Implement guidelines for emergency health services (#12)

Acute Care

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
	4.2 Collaborate with the PHSA in development of measures of the performance of surgical and procedural services in hospitals including measures of performance of the system in response to emergency treatments and procedures and the development of principles for establishing priority for care for non-emergency conditions/cases. Measures will be developed; principles in classifying cases as emergent or urgent/elective will be agreed to and a plan to measure the appropriateness of outcomes of selected procedures (RESIO) will be produced.	VP Medicine VP Clinical Services	- **PAT 03/04:** Participate in provincial initiative (#13) - Outputs/standards for surgical and procedural services adopted by the NHA (#13)

Implications of Acute Care Strategies:

- Chronic disease management strategies will be implemented in conjunction with home and community care, mental health, public health, and primary care. Chronic disease management is an integral component of the primary health care plan.
- Strategies to improve discharge planning and management of lengths of stay will improve appropriateness and effectiveness of care.
- Strategies to co-locate and integrate program and service delivery systems will impact on quality of care and service levels.
- Collaboration with provincial initiatives for emergency health services and surgical/procedural services will also impact on the quality of care and service levels.

Table 2. 2003-04 to 2005-06 Proposed Facility Changes

Name	Projected Total Beds 2003-04	2004-05	2005-06	Proposed 3 Year Changes	Comments
Chetwynd General Hospital	5	5	5	Targeted reduction from 6 to 5 operational beds was achieved in 2002-03	5 Multi Level Care beds also on site
Dawson Creek & District Hospital	45	43	43	Reduce acute beds from 45 to 43	Improved utilization to achieve target
Fort Nelson Hospital	20	15	15	Reduce from 20 to 15 beds	Reduction target of 10 beds in 2002-03 was not achieved. 3-year target amended to 15. Planning underway.
Fort St. John Hospital & Health Centre	44	44	44	Targeted reduction from 48 to 44 beds was achieved in 2002-03	Target met
Northeast HSDA	114	107	107	Reduce from 114 beds to 107 beds	Subject to outcome of planning underway at F
Lakes District Hospital and Health Centre – Burns Lake	13	13	13	Targeted reduction from 20 to 13 beds was achieved in 2002-03	South Side Clinic scheduled to open in 2003.
Stuart Lake Hospital – Ft St James	6	6	6	No change	6 Multi Level Care beds also on site – temporarily until new Complex Care facility opens in Vanderhoof in October 2004
Mackenzie & District Hospital	5	5	5	Targeted reduction from 6 to 5 operational beds was achieved in 2002-03	Target met
McBride & District Hospital	3	3	3	Targeted reduction from 6 to 3 operational beds was achieved in 2002-03	8 Multi Level Care beds also on site
Prince George Regional Hospital	196	185	185	Targeted bed capacity 0f 203 was achieved in 2002-03	Bed targets under review re: physician recruitment, NHA-wide services, UNBC Medical Program
G.R. Baker Memorial Hospital – Quesnel	31	31	31	Targeted reduction from 42 to 31 beds was achieved in 2002-03	Target met
St. John Hospital - Vanderhoof	24	24	24	Targeted reduction from 27 to 24 beds was achieved in 2002-03	Target met
Northern Interior HSDA	278	267	267	Reduce from 278 beds to 267 beds	Subject to outcome of planning underway at F George

Wrinch Memorial Hospital - Hazelton	9	9	9	Reduce to 9 beds from 2002-03 level of 15 beds	Plan under review
Kitimat General Hospital	18	16	16	Reduce from 18 to 16 beds	Although originally targeted to reduce to 10 beds, it was announced Fall 2002 there would be no reduction below 16 beds, and perhaps no move below 18 beds. (See also Mills Memorial – Terrace, and Prince Rupert)
Masset Hospital	4	4	4	No change	Target met. Chronic Care model being implemented.
Prince Rupert Regional Hospital	31	29	29	Reduce from 31 to 29 beds by coordinating some programs with Terrace and Kitimat	• Shared NW regional call for general surgery, obstetrics, orthopedics and, along with Smithers, pediatrics. • • Smithers and Hazelton. • • Rupert and Terrace radiologists share NW regional call • (see also Mills Memorial – Terrace & Kitimat)
Queen Charlotte Islands Hospital	5	4	4	Reduce from 5 to 4 beds	Plan is under review
Bulkley Valley District Hospital - Smithers	25	25	25	Maintain operational capacity at 25 beds	Target met
Stewart General Hospital	3	3	3	No changes	Target met
Mills Memorial Hospital - Terrace	52	49	49	Increase operational capacity from 39 beds in 2002-03 to 49	The formal confirmation of an ongoing 10 beds will not be made until additional resources become available. (See also Kitimat and Prince Rupert)
Northwest HSDA	147	139	139	Reduce from 147 beds to 139 beds	Subject to outcome of planning underway at C Hazelton, and Terrace/Kitimat.
NHA Totals	539	513	513	Decrease operational beds from 539 to 513	Targets dependent upon reviews being condu PGRH, Terrace/Kitimat, Hazelton, Ft Nelson,

4.4.2 Home and Community Care – Facility and Community

Home and Community Care

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
5. Develop long term care facilities (LTCF) to meet the needs of complex care clients	5.1 Develop and implement a transition plan for each catchment area for the upgrading or replacement of LTCFs through RFPs and reduction in capacity for intermediate care beds.	Regional Director H&CC	- **PAT 03/04:** 2% increase in clients with high care needs being cared for in their own home (#19) - Transition plans in place Apr/03 - Plans implemented Sep/03
	5.2 Assess needs and proceed with operational planning for the provision of sub-acute and convalescent beds – including swing beds.	VP Clinical Regional Director H&CC	- Decrease average length of stay in acute care beds (#8) - Plan for provision of sub-acute and convalescent beds developed
	5.3 Implement the new assessment tool for home care (MDS-HC).	Regional Director H&CC	- **PAT 03/04:** Implementation on track - Phase 2 implemented by Mar/04 (#23) - Full implementation by Mar/05 (#23)
	5.4 Implement the new assessment tool for residential care (MDS-V2.0).	Regional Director H&CC	- **PAT 03/04:** Implementation on track - Phase 2 implemented by Mar/04 (#24) - Full implementation by Mar/05 (#24)
6. Provide Independent Living Units	6.1 Implement catchment area redesign plans to provide independent living units.	Regional Director H&CC	- Increase number of independent living units to 145 by Mar/04 and to 328 by Mar/06 (#17)
7. Enhance community services, including palliative care	7.1 Develop and implement enhanced services including palliative care, respite services and Network of Excellence for Geriatric Services.	Regional Director H&CC	- Palliative Care strategy complete by Dec/03 - Network for geriatric services in place Mar/04 - Skill development for service providers conducted in each HSDA by Mar/04
	7.2 Provide service alternatives to accommodate ALC clients.	Regional Director H&CC	- Integrated ALC plans in place in each HSDA by Nov/03

Home and Community Care

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
	7.3 Continue consolidation and standardization of home support services.	Regional Director H&CC	- Home support services consistently provided across the NHA by Nov 03

Implications of Home and Community Care Strategies:

The shift from residential care to independent living will:

- enable people to live in the community longer; and
- ensure residential care is focused on those who require 24-hour care.
- Increased community services will allow seniors to remain in their own homes longer.
- Effective Home & Community Care should improve discharge planning and contribute to the reduction in ALC days.

4.4.3 Community Programs and Aboriginal Health

Community Programs and Aboriginal Health

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
MENTAL HEALTH & ADDICTIONS			
8. Shift to an early intervention approach	8.1 Improve early identification of illness through enhanced mental health and addiction screening and training and improved access to community and acute services.	Regional Director Mental Health and Addictions	- Decrease waitlist for Adolescent Psych Assessment Unit and adult unit - Decrease ALOS on APAU and adult unit - Appropriate utilization as evidenced by increased acuity/SMI on APAU and adult unit - Timelines: Apr/03 – Feb/04
9. Decrease level of ALC days for mental health and alcohol and drug patients	9.1 Develop community resources, staff capacity and local infrastructures to support/stabilize people within communities.	Regional Director Mental Health and Addictions Mental Health and Addictions Team Leaders	- **PAT 03/04:** 2% decrease in ALC days spent by mental health and alcohol and drug clients in hospitals once primary need for inpatient care has completed (#26) - Community/emergency response established - Community services linked to community response/intake processes - Timeline: Jun/03 – Nov/04
10. Improve the continuity of care and provide follow-up within 30 days of hospital discharge	10.1 Implement early intervention and recovery plans and consistency in discharge planning and follow-up including improved linkages with General Practitioners, and appropriate referral and communication processes. 10.2 Partner with Min. of Children and Family Development (MCFD) regarding adolescent	VP Medicine VP Clinical Services Regional Director Mental Health and Addictions	- **PAT 03/04:** 3% Increase proportion of persons aged 15-64 hospitalized for mental health diagnosis who receive community or physician follow-up within 30 days of discharge (#27) - Timeline: 2003-04 – Mental Health

Community Programs and Aboriginal Health

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
	services and develop protocol agreements.	Team Leaders and SYNAPSE Project Coordinator	2004-06 – Addictions - **PAT 03/04:** Increase proportion of mental health services received within the NHA (long term target 95% for acute and 98% in community) (#28)
11. Redesign Alcohol and Drug Programs	11.1 Work with Alcohol and Drug and mental health staff in each HSDA to: - Develop and implement a structure that provides alcohol and drug program management and leadership. - Develop and implement an effective service delivery model that is coordinated, linked and collaborative. - Provide a continuum of services across the NHA with services appropriately placed at the community, HSDA, and NHA levels.	Regional Director Mental Health and Addictions	- Structure and system of services put in place - Core services defined - Indicators developed - Development of Detox capacity across the NHA by Mar/04 - Development of a supportive recovery plan by Mar/04
12. Develop NHA-wide capacity through Riverview replacement beds	12.1 Develop and implement plan for Riverview replacement beds to increase NHA capacity to provide a continuum of mental health and addictions services by 2005.	Regional Director Mental Health and Addictions VP Clinical Services	- **PAT 03/04:** Transfer of Riverview beds (#30) Target: 39 units 03-04 17 units 04-05 - Construct facility in Terrace - Establish psycho-geriatric beds in Ft St John and Smithers
	12.2 Build capacity across the health care system to improve the management of people at risk for Mental Health and Addictions issues through skill development, and implementation of protocols.	Regional Director Mental Health and Addictions Team Leaders	- Increase appropriateness of crisis consultations in acute care and emergency and H&CC - Acute care facilities will have protocols in place for managing mental health and addiction services

Community Programs and Aboriginal Health

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)

Implications of Mental Health and Addictions Strategies:

- The shift to an early intervention approach increases accessibility and linkages with MCFD, other agencies and hospitals. It should also decrease the impact on Emergency Room services.
- Strategies will increase the linkage with the Aboriginal Health Plan through the development of partnerships that enable NHA-wide mental health, addictions and aboriginal services plan to address the continuum of needs in local communities in the north.
- Successful implementation of mental health and addictions strategies will require acute care, long-term care and other community services commitment to addressing mental health and addictions issues within their specialties.
- Strategies will build capacity across the health care system to improve the management of people at risk for Mental Health and Addictions issues through skill development, and implementation of protocols. Communities will have partnerships necessary to manage mental health and addictions issues locally.
- Strategies will require partnership with information services as the clinical information system implementation will support systems developments in Mental Health and Addictions and tracking of addictions clients.

Community Programs and Aboriginal Health

PUBLIC/POPULATION HEALTH

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
13. Collaborate with the MOH Planning in the development of Public Health Act and Public Health core programs	13.1 Facilitate dialogue and response to MOH Planning discussion paper and ensure NHA representation in provincial process.	Chief Medical Health Officer Reg Dir Prev Public Health Reg Dir Public Health Protect	- **PAT 03/04:** Collaboration with other HAs and MOH in development of core prevention and protection programs and in the review of literature and research of best practices and performance of other jurisdictions (#31 & #36)) - Timeline: Spring 2005
14. Create an NHA-wide system of integrated services	14.1 Develop a Public Health planning framework that includes program plans for: - communicable disease; - child/youth/family; - chronic disease and injury prevention; - expanded NHA-wide Tobacco Strategy; and - environmental health.	Chief Medical Health Officer Reg Dir Prev Public Health Reg Dir Public Health Protect	- Program plans showing evidence of coordination, and linkage with related programs in place by Sep/03
	14.2 Provide leadership to integrated planning and delivery of early child development services, and school & youth services in partnership with key stakeholders such as MCFD, School District, Child Development Centres and others, at the NHA and the community level.	Chief Medical Health Officer Reg Dir Prev Public Health	- Partnerships established to support: - Early child development - School and youth services in Terrace, Smithers, Prince Rupert and Quesnel by Mar/04, and Dawson Creek and Ft St John by Oct/04

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
15. Decrease the incidence of communicable disease in the NHA	15.1 Increase immunization rates for children and influenza and pneumococcal for high risk populations.	Chief Medical Health Officer Reg Dir Prev Public Health	- **PAT 03/04:** 83% immunization rate for 2-year olds (#32) - **PAT 03/04:** Maintain 85% influenza immunization rate for residents of care facilities (#33)
	15.2 Standardize communicable disease service delivery system and implement Internet Public Health Information System (iPHIS) across the north.	Chief Medical Health Officer Reg Dir Prev Public Health	- Structure for communicable disease services planning & implementation in place Oct/03 - iPHIS implemented Jun/03
16. Develop Population Health Strategy and Research Capacity	16.1 Develop an NHA population health strategy and develop NHA population health research capacity; including a comprehensive inventory of public health initiatives in the NHA.	Chief Medical Health Officer Reg Dirs Prev Public Health & Health Protect	- **PAT 03/04:** Population health strategy in place Mar/04 (#34) - Inventory of public health initiatives in place Mar/04
	16.2 Develop regular health status reports.	Chief Medical Health Officer	- Plan for health status reporting in place Jul/03 (#35)
	16.3 Reduce smoking attributable morbidity and mortality with a comprehensive tobacco strategy.	Chief MHO & Tobacco Steering Committee	- Structure for planning and service in place Fall/03
	16.4 Facilitate dialogue to develop a sustainability strategy for the NHA.	Chief MHO Reg Dir Public Health Protect	- Steering Committee in place Fall/03

Implications of Public/Population Health Strategies:

These strategies will:

- contribute to conditions that lead to improved population health;
- focus on 'upstream' preventive action;
- reduce demand for acute care over the long term;
- establish partnerships & coalitions with other Ministries, community members, agencies, and organizations; and
- engage the public in health promotion initiatives.

Community Programs and Aboriginal Health			
ABORIGINAL HEALTH			
NHA Priority	**Strategy**	**Lead Responsibility**	**Expected Results** (PAT=Performance Agreement Target)
17. Implement the Aboriginal Health Services Plan for the NHA	17.1 Provide Board, Management and key staff of the NHA with sufficient knowledge of legislative and jurisdictional issues of the "health transfer" process between Health Canada, First Nations, and the health and social programs available to First Nations, Inuit and Metis, to enable informed governance, management and service provision.	Director Aboriginal Health	- Meetings with FNIHB several times a year - Aboriginal Health Services Plan document used as a resource and reference manual - Joint action plans developed
	17.2 Improve access to primary and secondary prevention programs through partnerships with FNIHB and transferred organizations, friendship centers, and other Aboriginal, Inuit and Metis serving organizations.	Director Aboriginal Health	- Working jointly with FNIHB and transferred organizations on: - Injury Prevention - Dental Health - Diabetes Prevention

Community Programs and Aboriginal Health			
NHA Priority	**Strategy**	**Lead Responsibility**	**Expected Results** (PAT=Performance Agreement Target)
	17.3 Develop working relationships between NHA, transferred organizations, FNIHB and other federal and provincial organizations/agencies, and to develop the capacity of NHA front line and management staff in order to improve the planning, coordination and delivery of health services to First Nations, Inuit and Metis people. Specific initiatives will include:	Director Aboriginal Health	
	▪ Coordination of Communicable Disease Control and Environmental Health activities with EHOs and MHOs		- Memo of Understanding in place and data sharing in place with respective organizations and agencies for: ▪ Communicable diseases ▪ Environmental health activities
	▪ Joint planning of HIV/AIDS, Hepatitis, Pandemic Influenza and West Nile Virus Plans		- Integrated Service Plan
	▪ Development of an effective discharge planning process in acute care facilities for aboriginal people		- Plan developed
	▪ Development of mental health outreach and community response services for aboriginal communities		- Plan developed

Community Programs and Aboriginal Health

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
	17.4 Develop community specific action plans that focus on areas of common interest and opportunities to improve health or health services.	Director Aboriginal Health COOs HSAs	- Community action plans between NHA staff and First Nation communities

	17.5 Long term improvement in the health status of aboriginal people		- **PAT 03/04:** Improve Infant mortality (#37)
			- **PAT 03/04:** Improve Life expectancy (#38):
			  - Reduce injuries
			  - Reduce dental caries
			  - Reduce preventable admissions to hospital

Implications of Aboriginal Health Strategies:

- Strategies will lead to improved communications, development of relationships and capacity development.
- Initiatives will provide support for families and children across jurisdictional borders.

4.4.4 Primary Health Care

Primary Health Care

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
18. Implement the three year primary health care plan	18.1 Increase access to primary health care through the integration of services in: - community health centres in 6-8 communities - specialized health centre in Prince George designed to serve people who are socially/ economically disadvantaged and have multiple health needs.	VP Clinical Services COOs	- Community health centre development in 4 communities in year one - Development of phase one of a specialized health centre in Prince George
	18.2 Improve quality of primary health care through the implementation of initiatives that support the integration of community health services including: - professional and health care worker education and training; - implementation of applied technology to support the coordination of patient/client care by building on the NHA-wide information technology plan; and - public education.	VP Clinical Services COOs	- Education focused on chronic disease management, women's health, integrated service delivery models in year one (measures under development in each community health centre) - Increased use of evidence based care (measures under development in each community health centre site in year one) - Development and implementation of public communication plan

Implications of Primary Health Care Strategies:

- Strategies will impact access to care and improve quality of care and services.
- Strategies will link closely to NHA-wide:
    - mental health, public health, and home and community care plans;
    - communication strategy;
    - information management/systems strategy; and
    - chronic disease management plan.

4.4.5 Clinical Workforce

Clinical Workforce

NHA Priority	Strategy		Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
19. Forecast future requirements for clinical staff and implement strategies to recruit, retain, educate and develop its clinical workforce	19.1	Cooperate in Ministry-lead process to develop policies concerning standards of performance and reporting requirements concerning NHA responsibility for service agreements with physicians, consistent with the existing Framework Agreement between the Government and BCMA.	VP Medicine	- **PAT 03/04**: Cooperate in Ministry-led process (#15)
	19.2	Implement priorities for physician recruitment based on the Physician Human Resource Plan approved by the Board.	VP Medicine	
	19.3	Develop an implementation plan jointly with UBC and UNBC for UNBC Medical School, identifying capital, operating and medical staff implications.	VP Medicine COO Northern Interior	- Plan in place Sep 2003 - Implementation of plan 2003-04
	19.4	Develop a multi-year work force plan and education plan to ensure that the number of health professionals to deliver required programs and services are adequate.	VP Human Resources	- Education plan in place 2003 - Workforce Plan in place 2003-04
	19.5	Address nursing shortage through the review of staffing levels, staff mix (all clinical staff), and scope of practice of LPNs/RNs. Implement monthly reporting of nursing complement changes.	VP Clinical Services VP Human Resources	- NHA-wide policy defining LPN roles - Appropriate level and mix of direct care staffing - Reporting process implemented
	19.6	Plan to address the nursing shortage throughout the NHA.	CEO VP Medicine VP Clinical Services VP Human Resources	- Strategy by CEO to Board June 2003

Clinical Workforce

NHA Priority	Strategy	Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
	19.7 Implement an integrated workplace and health and safety initiative, the respect in workplace policy and training plan and a coordinated NHA education infrastructure.	VP Human Resources	- Improved workplace environment - 6 education initiatives in 2003 - Education calendar in place 2004

Implications of Clinical Workforce Strategies:

- With the implementation of the UNBC Medical School, 80-90% of the professional income of additional specialists would be generated by expanded provision of insured medical services. This expansion of activity would add $6-8 M of costs to the operation of PGRH and would increase stresses related to recruitment.

4.4.6 Organizational Support

Organizational Support

NHA Priority	Strategy		Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
20. Achieve benchmarks in administration and support	20.1	Move to achieve benchmarks in support services. Utilize technology. Centralize finance/payroll functions.	VP Operation Support Chief Financial Officer (CFO)	- **PAT 03/04:** 7% Reduction of annual expenditure for administrative and support services (excluding information systems) by 2004-05 (#40) - Identify and describe benchmarks in addition to Food / Laundry / Housekeeping (#44 to 49) - Finance and payroll centralized by Sep/04
21. Strengthen planning processes in the NHA	21.1	Prepare and present initial planning framework and strategic plan, proposed strategic planning cycle and community consultation strategy to the NHA Board for decision.	Chief Executive Officer	- Strategic planning cycle in place - Present initial plan Jun/03 - Implement process in 2003-04
	21.2	Develop a Decision Support Unit responsible for performance measurement and health information management to support planning processes.	CFO	- Unit in place Sep/03 - Work plans for component pieces of Decision Support Unit
22. Making one out of many	22.1	Complete IM/IT Strategic Plan for Board approval.	CFO	- Plan complete for Board approval Sep/03
	22.2	Implement NHA-wide Clinical Information Systems Plan in a phased approach across the NHA.	CFO	- Implementation as per IT strategic plan
	22.3	Continue to implement and support the Telehealth plan.	CFO	- Revised Telehealth Plan by Sep/03
	22.4	Prepare of Medical Staff Bylaws.	VP Medicine	- Bylaws complete
23. Focus on improving internal and external communications	23.1	Develop and implement a Communication Strategy.	CEO Director Communications	- Communication Strategy Framework approved and implemented 2003-04

Organizational Support

NHA Priority	Strategy		Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
24. Ensure quality services in the NHA	24.1	Develop and document a strategy for quality improvement in each program area.	VP Medicine VP Clinical Services	- Strategies developed
	24.2	Prepare for accreditation in 2004.	Director Quality Assurance	- Accreditation by CCHSA fiscal 2005 (Fall 2004)
25. Support services redesign	25.1	Complete implementation of redesign plans in Laboratory, Diagnostic Imaging, Materials Management, Food Services, Housekeeping and Laundry as initiated in 2002-03.	VP Operational Support	- **PAT 03/04:** 90% Chemotherapy patients begin treatment within 4 weeks of being ready to treat - Operating results within budget (#14)
26. Development of Capital Plan	26.1	Complete an integrated capital plan for all NHA facilities and capital equipment for Board approval.	VP Operational Support	- Capital Plan submission to Board by October 2003 - Capital Plan approval by Board November 2003
	26.2	Maintain regular and effective communication with Regional Hospital Districts to support capital plan implementation.	VP Operation Support	- Cost Sharing Agreements in place

Implications of Organization Support Strategies:

- While meeting the Ministry of Health's Performance Agreement expectations for reduction of Administration and Support Staff, the NHA must ensure that we have sufficient administrative capacity to deliver our programs and meet our other Performance Agreement Targets.
- Implementation of strategic planning cycle will cause the planning process for all programs and services to meet the timeframes of the cycles.
- The development of a Decision Support Unit may require additional resources or redeployment of existing resources which may impact on other services such as health records, information technology, financial services, etc.
- The clinical information system is a major capital project that will be ongoing for the next 5 to 7 years. There will be major impact on the staffing of clinical and other areas.

4.4.7 Financial Management

Financial Management

NHA Priority	Strategy		Lead Responsibility	Expected Results (PAT=Performance Agreement Target)
27. Ensure efficient and effective use of limited resources	27.1	Develop an operational plan and a risk assessment for critical examination of current targets and processes.	CEO	- Operational plan in place
	27.2	Work with the Ministry of Health Services to maximize funding allocations.	CEO	- Participate on Ministry Funding Methodology Sub-Committee
	27.3	Comply with all required changes in reporting requirements as a result of the Province's implementation of generally accepted accounting principles (GAAP) and the inclusion of health authorities in the government reporting entity.	Chief Financial Officer	- **PAT 03/04:**Compliance with implementation of GAAP
	27.4	Manage and deliver programs and services for fiscal 2003-04 such that operating results are equivalent or better than those projected in the budget management plans.	CEO	- Balanced budget or surplus over 2002-03 and 2003-04 - **PAT 03/04:**Total equity at Mar/05 = or greater than total equity at Mar/01 (excluding externally restricted) (#41)

Implications of Financial Management Strategies:

- Demonstrate efficient and effective utilization of scarce resources.
- Ensure the NHA receives a fair allocation of provincial resources.
- Inability to successfully manage resources could cause the loss of opportunity for enhanced services.

APPENDIX A – Cross Reference with Ministry of Health Goals and Performance Agreement

This table cross-references the Ministry of Health Goals and Performance Agreement performance expectations with Northern Health Authority priorities. Each provincial expectation is cross-referenced to the specific priority as identified by the priority number, description and page number.

Provincial Expectation	NHA Priority Number	NHA Priority	Page Number
Ministry of Health Goal 1: • **High quality patient-centred care**	1.	Address issues of access to acute care	21
	2.	Foster the development of community health center models of service delivery in small communities	22
	3.	Develop and implement a Chronic Disease Management Strategy	22
	5.	Develop long term care facilities to meet the needs of complex care clients	26
	6.	Provide independent living units	26
	7.	Enhance community services, including palliative care	26
	8.	Shift to an early intervention approach for mental health and addictions	28
	9.	Decrease level of ALC days for mental health and alcohol and drug patients	28
	10.	Improve the continuity of care and provide follow up within 30 days of hospital discharge	29
	12.	Develop NHA-wide capacity through Riverview replacement beds	31
	14.	Create an NHA-wide system of integrated services	33
	18.	Implement the three-year primary care plan	36
	24.	Ensure quality services in the NHA	40
Ministry of Health Goal 2: • **Improved health and wellness for British Columbians**	13.	Collaborate with the MOH Planning in the development of Public Health Act and Public Health core programs	31
	15.	Decrease the incidence of communicable disease in the NHA	32
	11.	Redesign Alcohol and Drug Programs	29
	16.	Develop population health strategy and research capacity	32
	17.	Implement the Aboriginal Health Services Plan for the NHA	33
Ministry of Health Goal 3: • **A sustainable, affordable public health system**	19.	Forecast future requirements for clinical staff and implement strategies to recruit, retain, educate and develop its clinical workforce	37

Provincial Expectation	NHA Priority Number	NHA Priority	Page Number
Ministry Health Goal 3 cont'd	20.	Achieve benchmarks in administration and support	39
	21.	Strengthen planning processes in the NHA	39
	22.	Making one out of many	39
	23.	Focus on improving internal and external communications	39
	25.	Support services redesign	40
	26.	Development of Capital Plan	40
	27.	Ensure efficient and effective use of limited resources	41
Performance Agreement 1: • **Emergency Health Services**	4.	Participate in provincial health system redesign	22
Performance Agreement 2: • **Surgical and Procedural Services**	4.	Participate in provincial health system redesign	22, 23
Performance Agreement 3: • **Acute Care Services**	1.	Address issues of access to acute care	21
Performance Agreement 4: • **Mental Health Services**	8.	Shift to an early intervention approach	28
	9.	Decrease level of ALC days for mental health and alcohol and drug patients	28
	10.	Improve the continuity of care and provide follow up within 30 days of hospital discharge	29
	12.	Develop NHA-wide capacity through Riverview replacement beds	30
Performance Agreement 5: • **Home and Community Care**	5.	Develop long term care facilities to meet the needs of complex care clients	26
Performance Agreement 6: • **Public/Population Health**	13.	Collaborate with MOH planning in the development of Public Health Act and Public Health core programs	31
	15.	Decrease the incidence of communicable disease in the NHA	32
Performance Agreement 7: • **Support and Admin. Services**	20.	Achieve benchmarks administration and support	39
	27.	Ensure efficient and effective use of limited resources	41
Performance Agreement 8: • **Aboriginal Health**	17.	Implement the Aboriginal Health Services Plan for the NHA	33
Performance Agreement 9: • **Health Authorities and Physician Services**	19.	Forecast future requirements for clinical staff and implement strategies to recruit, retain, educate and develop its clinical workforce	37

APPENDIX B – Summary of Indicators and Targets

Key Performance Indicators and 2003-04 Targets for Acute Care

1. Patient days/1000 by HSDA and NHA (age standardized)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	852	809	n/a	TBD	TBD	TBD	TBD
NI	743	690	n/a	TBD	TBD	TBD	TBD
NW	740	749	n/a	TBD	TBD	TBD	TBD
NHA	764	731	n/a	TBD	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Calculation of this indicator requires knowledge of patient days for NHA residents occurring at non-NHA facilities and Out of Province. Due to data problems at CIHI, the Ministry of Health has not been able to produce data for 2002-03 for this indicator. Rates have dropped by 15% over the last 6 years for the NHA compared to 17% for BC. NHA was 34% above the BC rate in 2001-02.

2. Patient days/1000 by HSDA and NHA (crude rate)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	664	n/a	n/a	TBD	TBD	TBD	TBD
NI	600	n/a	n/a	TBD	TBD	TBD	TBD
NW	577	n/a	n/a	TBD	TBD	TBD	TBD
NHA	607	n/a	n/a	TBD	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Calculation of this indicator requires knowledge of patient days for NHA residents occurring at non-NHA facilities and Out of Province. Due to data problems at CIHI, the Ministry of Health has not been able to produce data for 2001-02 for this indicator.

3. Patient days/1000 by HSDA and NHA (NHA only – crude rate)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	512	530	518	512	500	496	491
NI	612	552	551	544	532	530	527
NW	616	546	486	485	487	485	469
NHA	592	546	526	521	513	510	503
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Reflects patient days at NHA facilities. Uses P.E.O.P.L.E. 27 population projections.

4. Acute Beds Set Up and in Operation

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	no data	162	119	114	107	107	TBD
NI	no data	349	285	278	267	267	TBD
NW	no data	204	143	147	139	139	TBD
NHA	no data	715	547	539	513	513	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Targets dependent upon reviews being conducted at PGRH, Terrace/Kitimat, Hazelton, Ft Nelson, QCI

5. Acute Patient Days

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	32,797	33,645	32,854	32,500	32,029	32,029	32,029
NI	93,406	83,206	82,718	81,500	79,661	79,661	79,661
NW	51,683	45,067	39,488	39,000	39,055	39,055	39,055
NHA	177,886	161,918	155,061	153,000	150,745	150,745	150,745
Performance Agreement Targets	None	None	None	None	None	None	TBD

Note: (Total Patient Days = acute + rehab + ALC + newborns).

6. Alternate Level of Care Days by HSDA and NHA

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	3,382	4,046	3,246	3,084	2,930	2,842	TBD
NI	12,157	9,938	5,776	5,847	5,213	5,056	TBD
NW	15,648	10,067	6,852	6,509	6,184	5,998	TBD
NHA	31,187	24,051	15,874	15,440	14,327	13,896	TBD
Performance Agreement Targets	None	None	5% decrease	5% decrease	5% decrease	3% decrease	TBD

Note: Targets derived by applying Performance Agreement targets to 2002-03 actuals. However, based on 2001-02 actuals the NHA has already achieved the required 18% 4-year decrease in ALC days.

7. Alternate Level of Care days as % of total inpatient days by HSDA

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	10.3%	12.0%	9.9%	9.5%	9.1%	8.9%	TBD
NI	13.0%	11.9%	7.0%	7.2%	6.5%	6.3%	TBD
NW	30.3%	22.3%	17.4%	16.7%	15.8%	15.4%	TBD
NHA	17.5%	14.9%	10.2%	10.1%	9.5%	9.2%	TBD
Performance Agreement Targets			5% decrease	5% decrease	5% decrease	3% decrease	TBD

Note: This is an indicator found in the Home & Community Care section of the Performance Agreement but is listed here along with other acute care patient day figures. In this document the % performance agreement targets are applied to the number of ALC days (see table #6).

8. Average Length of Stay by HSDA and NHA

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	5.0	5.1	4.0	4.0	TBD	TBD	TBD
NI	5.9	5.7	5.9	5.9	TBD	TBD	TBD
NW	5.4	5.3	4.5	4.5	TBD	TBD	TBD
NHA	5.6	5.5	5.0	5.0	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: No targets are stipulated in the performance agreement. Average length of stay dependent on case mix and other factors. Target set for 2003-04 reflects maintenance of 2002-03 actual average length of stay.

9. May Not Require Hospitalization (cases/1000) by HSDA and NHA (age-standardized)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	10.9	n/a	n/a	decrease	decrease	decrease	
NI	8.5	n/a	n/a	decrease	decrease	decrease	
NW	9.5	n/a	n/a	decrease	decrease	decrease	
NHA	9.3	n/a	n/a	decrease	decrease	decrease	
Performance Agreement Targets				5% decrease	5% decrease	5% decrease	

Note: Due to data problems at CIHI, the Ministry of Health has not been able to produce data for 2001-02 or 2002-03 for this indicator.
Note: The BC rate in 2000-01 was 6.9. The NHA's value of 9.3 is 35% above the BC rate. Rates have been falling in the NHA and in BC for the last 5 years i.e. the NHA's rate has fallen by 35% and the BC rate has fallen by 28%.

10. Emergency Room Visits

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	n/a	n/a	66,576	66,576	TBD	TBD	TBD
NI	n/a	n/a	86,075	86,075	TBD	TBD	TBD
NW	n/a	n/a	44,818	44,818	TBD	TBD	TBD
NHA	n/a	n/a	197,469	197,469	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note:

- 2000-01 and 2001-02 pre-NHA numbers are not available/reliable.
- 2002-03 actual figures include some period estimates at some facilities.
- No targets are in the Performance Agreement.
- 2003-04 targets reflect maintenance of 2003-04 levels.

11. Percentage of patients with diabetes receiving at least 2 blood glucose (HbA1c) tests during the year

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	n/a	25%	n/a		TBD	TBD	TBD
NI	n/a	32%	n/a		TBD	TBD	TBD
NW	n/a	19%	n/a		TBD	TBD	TBD
NHA	n/a	28%	n/a	35% *	TBD	TBD	TBD
Proposed Performance Agreement Targets	*None*	*None*	*45%*	*55%*	*60%*	*65%*	*TBD*

Note: At present the Ministry of Health is developing data from a linked database (MSP, hospitalizations, and Pharmacare) to track chronic diseases. Only 2001-02 data was available from the Ministry of Health and the accuracy of this data continues to be refined.
* estimate

12. Provincial guidelines for emergency health services

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA	n/a	n/a	n/a	Implement	Improve Performance	Evaluation	TBD
Performance Agreement Targets	n/a	n/a	n/a	Implement	Improve Performance	Evaluation	TBD

Note: NHA is working with PHSA on this provincial strategy.

13. Provincial standards/outputs for surgical and procedural services

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA	n/a	n/a	Participate	Participate	Improvement	TBD	TBD
Performance Agreement Targets	n/a	n/a	Participate	Participate	Improvement	TBD	TBD

Note: NHA is working with PHSA on this provincial strategy.

HSDA	Actual 2000-01	Actual 2001-02	ACTUAL 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	These figures have not been tracked historically			TBD	TBD	TBD	TBD
NI				TBD	TBD	TBD	TBD
NW				TBD	TBD	TBD	TBD
NHA				TBD	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	90%	90%	90%	TBD

Note: This indicator requires clarification by the Ministry of Health. A process for tracking this statistic will need to be developed.

15. Cooperate in Ministry-Led Process for Management and Reporting of Physician Services

HSDA	Actual 2000-01	Actual 2001-02	ACTUAL 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA				Cooperation	Cooperation	Cooperation	
Performance Agreement Targets				Cooperation	Cooperation	Cooperation	

Note:

Key Performance Indicators and 2003-04 Targets for Home and Community Care

16. Home and Community Care Beds in Operation

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	251	266	264	Transition	158	TBD	TBD
NI	495	495	484	Transition	417	TBD	TBD
NW	265	269	269	Transition	206	TBD	TBD
NHA	1,011	1,030	1,017	Transition	781	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: These are Complex Care beds. 2003-04 is a transition year towards the targets set for 2004-05

17. Independent Living Units

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	n/a	n/a	66	Transition	79	TBD	TBD
NI	n/a	n/a	32	Transition	151	TBD	TBD
NW	n/a	n/a	31	Transition	98	TBD	TBD
NHA	n/a	n/a	129	Transition	328	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: These are Assisted Living and Independent Living with Support Services Units. 2003-04 is a transition year towards the targets set for 2004-05

18. Clients with high level care needs (IC2 and above) receiving services

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	522	511	472	496	520	TBD	TBD
NI	1,048	1,023	942	989	1,039	TBD	TBD
NW	512	562	501	526	552	TBD	TBD
NHA	2,082	2,096	1,915	2,011	2,111	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Targets in 2003-04 and 2004-05 are 5% increases in each year over the 2002-03 actual.

19. High Care Needs Clients (IC2 and above) being cared for in their own home

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	42.7%	42.1%	37.1%	39.1%	44.1%	TBD	TBD
NI	47.3%	46.1%	38.0%	40.0%	45.0%	TBD	TBD
NW	38.7%	39.0%	36.9%	38.9%	43.9%	TBD	TBD
NHA	43.5%	43.8%	37.5%	39.5%	44.5%	TBD	TBD
Performance Agreement Targets				2% increase	5% increase	TBD	TBD

Note: Baseline is number as of March 31, 2002. Also note these percentages are subject to large year-to-year variations due to low numbers. For example the NI between 2001-02 and 2002-03 showed a change from 46% to 38% reflective of a 105 (373-268) person drop in the numerator and a 103 (809-706) person drop in the denominator.

20. Home Care Nursing Program Hours

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	8,482	8,867	8,945	8,945	TBD	TBD	TBD
NI	28,128	24,125	28,199	28,199	TBD	TBD	TBD
NW	16,434	17,014	18,052	18,052	TBD	TBD	TBD
NHA	53,044	50,006	55,196	55,196	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: H&CC are currently working on target figures.

21. Community Rehabilitation Program Hours

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	n/a	n/a	n/a	n/a	TBD	TBD	TBD
NI	n/a	n/a	6,433	6,562	TBD	TBD	TBD
NW	n/a	n/a	n/a	n/a	TBD	TBD	TBD
NHA	n/a	n/a	6,433	6,562	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Only the Northern Interior HSDA has tracked community rehabilitation hours, and that only starting in 2003-03 in Vanderhoof, Quesnel, and Prince George. H&CC are currently working on target figures.

22. Home Support Hours

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	76,143	73,157	67,998	69,358	TBD	TBD	TBD
NI	185,523	192,793	154,231	157,316	TBD	TBD	TBD
NW	81,288	98,491	101,225	103,250	TBD	TBD	TBD
NHA	342,954	364,441	323,454	329,924	TBD	TBD	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: These figures do not reflect the total hours provided by the Home Support agencies for all programs within the NHA. The major program: Long Term Care is accurate, however. Also, Home Support hours have decreased due to withdrawal of non personal care services but are expected to increase again. H&CC are currently working on target figures.

23. Implement MCS-HC over 3 years

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA	n/a	n/a	n/a	Phase-2 Completed	Fully implemented	n/a	n/a
Performance Agreement Targets	None	None	None	On track	Fully implemented	n/a	n/a

Note:

24. Implement MDS-V2.0 over 5 years

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA	n/a	n/a	n/a	Phase-2 Completed	On track	On track	Fully implemented
Performance Agreement Targets	None	None	None	On track	On track	On track	Fully implemented

Note:

Key Performance Indicators and 2003-04 Targets for Community Programs

MENTAL HEALTH

25. Average patient age at first contact with a physician or health service provider for serious mental illness

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE		Performance indicator under development by the Ministry of Health		Decrease			
NI				Decrease			
NW				Decrease			
NHA				Decrease			
Performance Agreement Targets				Decrease			

Note: Goal is to decrease age at first contact

26. ALC days spent by mental health patients (15-64) in hospitals once the primary need for inpatient care has comp

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	1	0	0	Decrease	Decrease	TBD	TBD
NI	164	469	34	Decrease	Decrease	TBD	TBD
NW	40	56	284	Decrease	Decrease	TBD	TBD
NHA	205	525	318	Decrease	Decrease	TBD	TBD
Performance Agreement Targets			0% decrease	2% decrease	2% decrease	TBD	TBD

Note: Figures supplied by Ministry of Health. Data does not appear correct, especially for Northeast.

27. Proportion of persons aged 15 to 64 hospitalized for a mental diagnosis who receive community and/or physician within 30 days of discharge

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	69.5%	71.0%	76.6%	77.0%	80.0%	Increase TBD	TBD
NI	73.1%	73.8%	69.7%	79.8%	82.8%	Increase TBD	TBD
NW	66.3%	69.3%	66.4%	72.3%	75.3%	Increase TBD	TBD
NHA	70.1%	71.7%	69.9%	77.7%	80.7%	Increase TBD	TBD
Performance Agreement Targets			3% increase	3% Increase	3% Increase	Increase TBD	

Note: Figures supplied by Ministry of Health. Annual % increases applied using 2001-02 as the base year.

28. Proportion of mental health services age 15 to 64 received within the NHA

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	93.5%	94.5%	n/a	Increase	Increase	Increase	TBD
NI	89.9%	91.9%	n/a	Increase	Increase	Increase	TBD
NW	79.7%	89.5%	n/a	Increase	Increase	Increase	TBD
NHA	91.4%	93.6%	n/a	Increase	Increase	Increase	TBD
Performance Agreement Targets				Increase	Increase	Increase	

Note: Long-term goal is 95% for acute and 98% for Community. (2002-03 data not available from Ministry of Health. Other data sourced from PURRFECT 8.0 Summary Referral Patterns Matrix Summary Report MCC-19)

29. Number of mental health clients accessing community and/or physician services as % of total population

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE		Performance indicator under development by the Ministry of Health					
NI							
NW							
NHA							

Note:

30. Development of Riverview replacement units

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA			10	39	17		
Performance Agreement Targets				22	0	35	

Note: 10 beds were completed in 2002-03 for a total of 25.

Key Performance Indicators and 2003-04 Targets for Community Programs

PUBLIC/POPULATION HEALTH

31. Continued collaboration with all other health authorities and MOH in the development of core prevention and p programs, review of literature and research of best practices and performance in other jurisdictions

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA				Collaboration	Implementation		
Performance Agreement Targets				Collaboration	Implementation		

Note:

32. Percentage of 2-year olds with up-to-date immunizations (Diphtheria, Pertussis, Tetanus, Polio – DPTP)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	72.2	80.0	77.1	83.0%	Maintain or improve upon 83% immunization rate		TBD
NI	88.0	87.9	86.7	88.7%			TBD
NW	81.5	81.5	76.0	83.0%			TBD
NHA							
Performance Agreement Targets				83% or better	TBD	TBD	TBD

Note: New PAT definition is: completed series of immunizations in accordance with the routine childhood immunization schedule. The above table cites DPTP only.

33. Influenza Immunization for Residents of Care Facilities

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE			83.3%	85% +	increase	increase	TBD
NI			77.9%	85% +	increase	increase	TBD
NW			98.8%	maintain	maintain	maintain	TBD
NHA							TBD
Performance Agreement Targets				85% or more	TBD	TBD	TBD

Note: Data integrity issues due to incomplete reporting. Provincial benchmark is 90% for the residential population.

34. Population Health Strategy

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA				In Place			
Performance Agreement Targets				None			

Note: This was a proposed Performance Agreement item.

35. Health Status Reports

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA				Reporting system in place			
Performance Agreement Targets				None			

Note: This was a proposed Performance Agreement item.

36. Compliance with New Public Health Act

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA					Compliance		
Performance Agreement Targets					Compliance		

Note:

Key Performance Indicators and 2003-04 Targets for Community Programs

37. Infant Mortality (Rate per 1,000 live births)

HSDA	Actual *1995-1999*	Actual *1991-2001*	Actual 2002-03	2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	6.7	7.5	n/a	Improve	Improve	Improve	TBD
NI	10.2	8.0	n/a	Improve	Improve	Improve	TBD
NW	8.7	8.2	n/a	Improve	Improve	Improve	TBD
NHA	n/a	n/a	n/a	Improve	Improve	Improve	TBD
Performance Agreement Targets				Improve	Improve	Improve	TBD

Note: Data prepared by Health Canada First Nations Inuit Health Branch and BC Vital Statistics. 1991-2001 is the most recent 10-year rolling data set for the Status Indian population. Due to the small number of actual deaths (76 in ten years), the rate is subject to variation i.e. small changes in numbers can lead to large changes in rates.

38. Life Expectancy

HSDA	Actual *1995-1999*	Actual *1997-2001*	Actual 2002-03	2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	76.5	74.2	n/a		Improve	Improve	TBD
NI	73.5	73.2	n/a	Improve	Improve	Improve	TBD
NW	75.7	76.1	n/a	Improve	Improve	Improve	TBD
NHA	n/a	n/a	n/a		Improve	Improve	TBD
Performance Agreement Targets				Improve	Improve	Improve	TBD

Note: Data prepared by Health Canada First Nations Inuit Health Branch and BC Vital Statistics. 1997-2001 is the most recent 5-year rolling data set for the Status Indian population.

39. Southside Health Centre

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA			Under Construction	Services begin	Open	Open	
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Health Centre servicing the south side of Francois Lake, South of Burns Lake.

Key Performance Indicators and 2003-04 Targets for Operational Supports

40. Administrative and Supportive Services $ Expenditures, and as % of Total Expenses

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA %	Pre-NHA	26.6%	22.7%	22.9%	23.0%	23.0%	TBD
NHA $	Pre-NHA	$98,189	$90,203	$91,315	$91,315	$91,315	TBD
Performance Agreement Targets			Reduce	Reduce	7% reduction over 2001-02 levels	No further reduction	TBD

Note: The required 7% reduction is based on the $ expenditure in 2001-02 being reduced by 7% by 2004-05. The $ figures are expressed in ($000's).

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NHA	($8,900)	($5,100)	$3,799	($3,799)	Balanced	Balanced	Balanced
Performance Agreement Targets			Balanced over two years		Balanced	Balanced	TBD

Note:

- The $ figures represent the operating surplus/(deficit) and are expressed in ($000's).
- According to the Performance Agreement the total equity (excluding externally restricted funds) at March 31, 2005, must be equal to or better than the total equity (excluding externally restricted funds) as at March 31,2001.
- Figures exclude surplus for Wrinch Memorial Hospital in 2002-03.

Key Performance Indicators and 2003-04 Targets for Operational Supports

42. Units per FTE Benchmark for Lab

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	n/a	n/a	7,500	7,500	7,500	7,500	TBD
NI	n/a	n/a	7,500	7,500	7,500	7,500	TBD
NW	n/a	n/a	5,900	7,500	7,500	7,500	TBD
NHA	n/a	n/a	7,000	7,500	7,500	7,500	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Laboratory benchmark is 7500 units per FTE per period for large, and 6000 units per FTE per period for small and medium. The higher benchmark for HSDA and NHA is used as the much larger departments overshadow the small departments in the small hospitals and D&T centres. (Numbers rounded to the nearest 100)

43. Units per FTE Benchmark for Diagnostic Imaging

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	n/a	n/a	7,800	maintain	maintain	maintain	TBD
NI	n/a	n/a	7,000	maintain	maintain	maintain	TBD
NW	n/a	n/a	4,900*	6,000	improve	improve	TBD
NHA	n/a	n/a	6,500	improve	improve	improve	TBD
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Imaging benchmark is 6000 units per FTE per period for large, and 4000 units per FTE per period for small and medium. The higher benchmark for HSDA and NHA is used as the much larger departments overshadow the small departments in the small hospitals and D&T centres. (Numbers rounded to the nearest 100) * Additional initiatives are underway to bring this HSDA up to target.

Key Performance Indicators and 2003-04 Targets for Operational Supports

SUPPORT

44. Housekeeping ~ Square Meters Cleaned per Productive FTE (Acute)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target	Target 2004-05	Target 2005-06	Target 2006-07
NE	Information was not maintained in prior years at all sites			1,022	See Note		
NI				1,022			
NW							
NHA				1,022			
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Alternate Service Delivery options are being pursued; if successful, appropriate targets and benchmarks will be developed based on industry standards.

45. Housekeeping ~ Square Meters Cleaned per Productive FTE (Multi Level Care)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	Information was not maintained in prior years at all sites			1,208	See Note		
NI				1,208			
NW				1,208			
NHA							
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Alternate Service Delivery options are being pursued; if successful, appropriate targets and benchmarks will be developed based on industry standards.

46. Laundry – Kilograms of Soiled Laundry per FTE

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
Small sites	Actual data collected in the past was done with different methodologies at the various sites			30	See Note		
Large Sites				37			
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Alternate Service Delivery options are being pursued; if successful, appropriate targets and benchmarks will be developed based on industry standards.

47. Laundry – Kilograms of Soiled Laundry per Resident Day

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
Acute Care	Actual data collected in the past was done with different methodologies at the various sites			6.7	See Note		
Multi Level Care				3.7			
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Alternate Service Delivery options are being pursued; if successful, appropriate targets and benchmarks will be developed based on industry standards.

48. Food Services – Meals per Productive Labour Hour (Acute)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	Maintenance of past data was not consistent at all sites			5	See Note		
NI				5			
NW				5			
NHA							
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Alternate Service Delivery options are being pursued; if successful, appropriate targets and benchmarks will be developed based on industry standards.

49. Food Services – Meals per Productive Labour Hour (Multi Level Care)

HSDA	Actual 2000-01	Actual 2001-02	Actual 2002-03	Target 2003-04	Target 2004-05	Target 2005-06	Target 2006-07
NE	Maintenance of past data was not consistent at all sites			7	See Note		
NI							
NW				7			
NHA				7			
Performance Agreement Targets	None	None	None	None	None	None	None

Note: Alternate Service Delivery options are being pursued; if successful, appropriate targets and benchmarks will be developed based on industry standards.

APPENDIX C - Budget Management Plan

Budget Management Plan submitted to the Ministry of Health as a separate document.

APPENDIX D - Home and Community Care (HCC) Bridge Funding Spending Plan

Spending Plan submitted to the Ministry of Health as a separate document.